chotic discontinuation and continuation from patients' and clinicians' perspectives. Further information is needed about the psychometric properties in usual care settings.

PMH16

PHARMACIST-RUN METHADONE CLINIC IN A MALAYSIAN PUBLIC HEALTH CENTER: EVALUATING PATIENT SATISFACTION AND QUALITY OF LIFE OUTCOMES

Chiew GP[1], Shafie AA[2], Hassali MA[2], Awaisu A[2], Cheah WK[3]
[1]Larut Matang & Selama Health Office, Taiping, Perak, Malaysia; [2]Universiti Sains Malaysia, Minden, Penang, Malaysia; [3]Hospital Taiping, Taiping, Malaysia

OBJECTIVES: To assess the satisfaction and health-related quality of life (HRQoL) improvement of patients enrolled in a pharmacist-run Methadone Maintenance Therapy (MMT) program. **METHODS:** A cohort study design was used to measure satisfaction and to evaluate changes in HRQoL of patients after one month of receiving methadone treatment at Taiping Health Clinic. Respondent's satisfaction was measured by using an eight-item pre-validated questionnaire. A post-survey reliability analysis of the questionnaire showed a high internal consistency of the items (Cronbach's $\alpha = 0.785$). Meanwhile, the HRQoL was measured using a validated EQ-5D and EQ-VAS questionnaire that are administered by face-to-face interview in two phases, after 1 month interval. The data were analyzed by using both descriptive statistics (frequencies and percentages) and inferential statistics (χ^2 test, paired *t*-test and the McNemar χ^2 test). **RESULTS:** All 54 patients in MMT clinic participated, but only 40 (74.1%) completed this study. Average methadone dose in both phases were low (Phase One = 37.4 mg [SD = 22.2], Phase Two = 44.4 mg [SD = 21.3]) that caused majority of respondents wishing to increase their current dose. Respondents were not satisfied with needs to come clinic daily (n = 18, 33.4%) and did not believe that MMT clinic can help in cessation of drug abuse (n = 9, 16.7%). These two items were significantly associated with travelling distance of respondents to clinic ($P = 0.001$ and $P = 0.039$, respectively). Only pain/discomfort domain of the EQ-5D showed a significant improvement from the baseline ($P = 0.035$). EQ-VAS score significantly improved from 64.69 (SD = 16.7) at baseline to 71.43 (SD = 14.9) during the 1-month follow-up ($P = 0.008$). **CONCLUSIONS:** MMT program was able to improve patients' QoL even in short duration of time. Improvement on dissatisfactions toward travelling distance, needs to travel daily to clinic and inadequate dose will help to increase treatment success.

PMH17

COMPARISON OF HRQOL BETWEEN PATIENT RECEIVING METHADONE MAINTENANCE THERAPY (MMT) AND REHABILITATION PROGRAM

Abdul Ghani N, Shafie AA, Hassali MA
Universiti Sains Malaysia, Minden, Penang, Malaysia

OBJECTIVES: This study aims to compare the HRQoL between patients receiving methadone maintenance therapy (MMT) program with those in the rehabilitation program. **METHODS:** This was a cross-sectional study involving 400 randomly selected patients from two primary and secondary hospitals and one rehabilitation center (PUSPEN) in northern part of Malaysia. Consented patient was interviewed to collect their socio-demography, drug consumption and quality of life information. The quality of life was measured by using EQ-5D and EQ-VAS questionnaires. Their quality of life scores were then compared using independent *t*-test. **RESULTS:** Majority of the participants were male with mean age 38.49 (SD = 9.6) in MMT group and 34.77 (SD = 8.6) in rehabilitation group. Mean duration of treatment for MMT group was 17.5 months (SD = 15.74) and rehabilitation group was 7.8 months (SD = 3.52). EQ-5D score was significantly ($P = 0.01$) higher among MMT participants (mean = 0.783, SD = 0.190) compared to those in rehabilitation program (mean = 0.707, SD = 0.227). Participants receiving MMT treatment also had lesser problems in mobility (10.5% vs. 21%; $P < 0.01$), normal activity (6.5% vs. 15%; $P < 0.05$) and anxiety (54.5% vs. 71%; $P < 0.001$). There was no statistically difference found between the groups in self care activity and pain dimensions. However, EQ-VAS score was significantly lower in MMT group compared to rehabilitation group (65.5 [SD = 17.9] vs. 73.5 [SD = 17.6], $P < 0.001$). **CONCLUSIONS:** This study shows that treatment for patient with substance use disorder with MMT program can provide a better quality of life compared to rehabilitation program (PUSPEN). Variation seen between EQ-5D and EQ-VAS scores suggest that patients might perceived their health worst than the general population value.

PMH18

THE EFFECT OF DIAGNOSED, SELF-REPORTED, AND AT-RISK DEPRESSION ON HEALTH-RELATED QUALITY OF LIFE AND WORK PRODUCTIVITY IN JAPAN AND EUROPE

DiBonaventura MD[1], Fukuda T[2], Nagae T[3], Wagner JS[1], Stankus A[4]
[1]Kantar Health, New York, NY, USA; [2]Tokyo University, Tokyo, Japan; [3]York Pharma KK, Tokyo, Japan; [4]Kantar Health, Princeton, NJ, USA

OBJECTIVES: The aim of the current study was to establish the burden of depression (diagnosed, self-reported, and at-risk) in both Europe and Japan. **METHODS:** Data from the 2008 EU and 2008 Japan National Health and Wellness Survey (NHWS) were used. Patients were categorized into four groups: diagnosed depression, self-reported depression, at-risk for depression, and controls. Differences among these groups were examined on quality of life (mental (MCS) and physical component summary (PCS) scores of the SF-12v2), as well as overall work impairment, controlling for demographics and patient characteristics. **RESULTS:** In the EU, 5848 patients (10.9%) were diagnosed, 2037 (3.8%) were self-reported, 13,168 (24.6%) were at-risk, and 32,471 (60.7%) were controls. In Japan, 884 (4.4%) were diagnosed, 162 (0.8%) were self-reported, 5681 (28.4%) were at-risk, and 13,273 (66.4%) were controls. After controlling for demographics and patient characteristics, those with diagnosed depression (Adjusted Mean [M_{adj}] = 34.4), self-reported depression ($M\text{—}_{adj}$ = 35.5), and at-risk depression ($M\text{—}_{adj}$ = 41.0) reported significantly lower levels of MCS scores than controls (($M\text{—}_{adj}$ = 51.10, *P's* < 0.0001) across all countries. The gap between controls and self-reported depression ($b = 3.18$, $P < 0.0001$) and at-risk depression ($b = 0.63$, $P < 0.001$) was significantly greater in Japan than in the EU. Both those with diagnosed (M_{adj} = 46.2) and at-risk ($M\text{—}_{adj}$ = 49.4) depression reported significantly lower levels of PCS than controls ($M\text{—}_{adj}$ = 49.6, *P's* < 0.05). Finally, those diagnosed with depression ($M\text{—}_{adj}$ = 39.2%), self-reported depression ($M\text{—}_{adj}$ = 30.9%), and at-risk for depression ($M\text{—}_{adj}$ = 23.3%) all reported significantly more overall work impairment than controls ($M\text{—}_{adj}$ = 12.8%). There was also a significant interaction, such that the difference in impairment between patients diagnosed with depression and controls was significantly greater in Japan ($P < 0.05$). **CONCLUSIONS:** Levels of diagnosed and self-reported depression were lower in Japan than in Europe, yet rates of at-risk depression were higher. Although the burden of depression was substantial, the results suggest that the work impairment burden in Japan is significantly greater than in the EU.

PMH19

THE BURDEN OF DIAGNOSED, SELF-REPORTED, AND AT-RISK DEPRESSION IN CHINA AND EUROPE

DiBonaventura MD[1], Liu GG[2], Wagner JS[1], Stankus A[3]
[1]Kantar Health, New York, NY, USA; [2]Peking University, Beijing, China; [3]Kantar Health, Princeton, NJ, USA

OBJECTIVES: The objective of this project was to assess the burden of depression in terms of quality of life and work impairment in the EU and China. **METHODS:** Data were obtained from the 2008 EU and 2009 China National Health and Wellness Survey (NHWS). Patients were categorized into four groups: diagnosed depression, self-reported depression, at-risk for depression, and controls. Differences among these groups were examined on quality of life (mental (MCS) and physical component summary (PCS) scores of the SF-12v2), as well as overall work impairment, controlling for demographics and patient characteristics. **RESULTS:** In the EU, 5848 patients (10.9%) were diagnosed, 2037 (3.8%) were self-reported, 13168 (24.6%) were at-risk, and 32471 (60.7%) were controls. In China, 339 (2.5%) were diagnosed, 348 (2.6%) were self-reported, 3883 (29.2%) were at-risk, and 8752 (65.7%) were controls. Adjusting for demographics and comorbidities, those with diagnosed ($b = -16.00$, $P < 0.0001$) and self-reported ($b = -14.42$, $P < 0.0001$) depression, and those at-risk for depression ($b = -9.22$, $P < 0.0001$) reported significantly lower MCS than controls. Those diagnosed ($b = -3.62$, $P < 0.0001$) and at-risk ($b = -0.47$, $P = 0.0022$) for depression reported significantly lower PCS than controls. In addition, the MCS difference between those with diagnosed, self-reported, or at-risk depression relative to controls was significantly greater in Europe than in China ($b = 5.88$, $P < 0.0001$; $b = 5.60$, $P < 0.0001$; $b = 3.49$, $P < 0.0001$, respectively). However, the PCS gap between patients at-risk for depression and controls was significantly greater in China than in Europe ($b = -0.99$, $P < 0.0001$). Finally, the work impairment gap between patients with diagnosed, self-reported, or at-risk depression and controls was significantly greater in Europe than in China ($b = -0.35$, $P = 0.0002$; $b = -0.40$, $P < 0.0001$; $b = -0.08$, $P = 0.0455$, respectively). **CONCLUSIONS:** Depression was associated with a substantial burden on patients. The impact of depression on mental quality of life and work impairment was greatest in Europe while the impact of depression on physical quality of life was greatest in China.

MENTAL HEALTH – Health Care Use & Policy Studies

PMH20

SWITCHING BETWEEN SSRI BRANDS IN AUSTRALIA

Ortiz MS[1], Calcino G[2]
[1]University of NSW, Darlinghurst, NSW, Australia; [2]HI Connections, Canberra, ACT, Australia

OBJECTIVES: To study the extent of brand substitution and switching between Selective Serotonin Reuptake Inhibitors (SSRI) available on the Pharmaceutical Benefit Scheme (PBS). **METHODS:** PBS prescription claims data provided by Medicare Australia of a 10% random sample of all Australian long-term concession card holders covering the time period August 2007 through July 2008 were assessed. Patients had to fill at least four prescriptions for an SSRI with generics over the 1-year period (fluoxetine [2 doses forms with up to 12 brands], fluvoxamine [2 strengths with up to 5 brands], paroxetine [1 strength with 11 brands] and sertraline [2 strengths with up to 13 brands]). The proportions of non-switchers (single brand only) and multiple switchers (two or more switches between brands) were determined for each strength of each SSRI molecule. **RESULTS:** A total of 18,691 Concessional patients filled at least four prescriptions for a SSRI in the 12-month time window. The majority of these patients received a single brand over the period: ranging from 49% for fluvoxamine to 67% for fluoxetine. Only a small proportion received three or more brands: ranging from 12% for fluoxetine to 16% for fluvoxamine. The proportions of multiple switchers varied slightly between molecules with: 22% for fluoxetine, 32% for fluvoxamine, 26% for paroxetine and 24% for sertraline. Switching was greater for